MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00001

00001

1. DECEASED-NAME (Type or print): First VERNON Middle A Last ALT
2a. DATE OF DEATH: JAN Month 4 Day 71 Year
2b. HOUR: 6:50 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: XXX 11-25-92
6. AGE (In years last Birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): W.VA.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: Carpenter
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 303 VIRGINIA AVE
14. FATHER'S NAME First CHARLES Middle A Last ALT
15. MOTHER'S MAIDEN NAME First IDA Middle E Last SCREVE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): War I
16b. SOCIAL SECURITY NO.: 210-10-2502
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 71, to Jan 4, 19 71, that (I) (we) last saw the deceased alive on Jan 4 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURS: [signature] DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 1/5/71
22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER PA
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan. 7, 1971
23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery
23d. LOCATION (City or Town) (County) (State): Moorefield, W.Va.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 7 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

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00002

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00002

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Marguerite | G. | Anderson | Jan. 19th. 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Female | White | 7/14 1896 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Chicago | USA. | MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Lonaconing | Watercliffe St. | Housewife Own | Home |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | Allegany | Lonaconing | YES / NO X | Watercliffe |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Ja mes | | Nelson | Annie | | Marks |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | | Mr. Adrian | Anderson, Brookville, MD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Coronary Occlusion (SON) | immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerosis - generalized | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from ____, 1966, to 1-19, 1971, that (I) (we) last saw the deceased alive an 1-10 1971, and that in (my) (aur) apinian deoth accurred on the date and hour and from the couses stated above (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L.R. Miles MD | MD | X | ☐ | ☐ | 1-21-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L.R. MILES, JR., M.D. | LONACONING MD. 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/22/1971 | Oak Hill Cemetery | Lonaconing, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George Eichhorn | Lonaconing, Md. | JAN 25 1971 | Vernon G. Randall |

VR A15 (4)
45M - 1/69

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FOR STATE HEALTH DEPT.

00003

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00003

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MH3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| DESSIE | MAY | AUSTIN |

2a. DATE KNOWN OF ESTIMATED DEATH: Month Day Year: JAN. 1, 1971 — 2b. HOUR: 8 A M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | JAN. 18, 1890 | 80 YRS. | | | | |

2c. DATE PRONOUNCED DEAD: Month Day Year: Jan. 1 1971 — 2d. HOUR: 8:30A M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | 400 BEDFORD STREET | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 400 BEDFORD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| UNKNOWN | | SHAFFER | UNKNOWN | | UNKNOWN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 235 78 8023 | JANET TRACY | CUMBERLAND, MARYLAND |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROSIS — - - - -

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Jan. 1, 1971

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county) CUMBERLAND, MD. 21502

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JAN. 4, 1971 | BLUEMONT CEMETERY | GRAFTON TAYLOR W.VA. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| BARTLETT FUNERAL HOME GRAFTON, W.VA. | JAN 5 1971 | Vernon O. Randall |

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00004

00004

1.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JAMES | GLENN | BEALL | JANUARY 14, 1971 | 12:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | JUNE 5, 1894 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | BEALLS LANE | OWN BUSINESS | INS.&REALTY |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 19 BEALLS LANE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| OLIN | | BEALL | FLORENCE | | GLENN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WWI | 214-32-2900 | MRS. J. GLENN BEALL, BEALLS LANE, | FROSTBURG, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Advanced Chronic ACVD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 yrs ??
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Pulmonary Insufficiency — 10 yrs ??
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Lung malignancy

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| NONE | ✓ | YES [ ] NO [X] | ✓ |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | ✓ 19 | ✓ |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | ✓ | ✓ | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from May, 1966, ta 1-14, 1971, that (I) (we) last saw the deceased alive an 1-14 1971, and that in (my) (our) opinion death occurred on the dote ond haur and fram the causes stoted abave, (I) (we) (did) (did not) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Martin M. Rothstein | | [X] | [ ] | [ ] | 1/15/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| MARTIN M. ROTHSTEIN, M.D. | 48 BROADWAY, FROSTBURG, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 1/16/71 | FROSTBURG MEM. PARK | FROSTBURG, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARTELLO M. SOWERS, HAFER-SOWERS FUNERAL Marilou M. Sowers | HOME, 60 W. MAIN, FROSTBURG | JAN 20 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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00005

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00005

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Delia | Middle: | Last: Bell | 2a. DATE OF DEATH Month: 1 Day: 24 Year: 71 | 2b. HOUR: 7:52 P.M. | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH: 2/14/85 | 6. AGE (In years last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): Cumberland, Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Cumb. Nursing Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Frostburg | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET AND NUMBER: Rt 1, Wright's Crossing | | |
| 14. FATHER'S NAME First: PETER | Middle: | Last: Bryner | 15. MOTHER'S MAIDEN NAME First: MAGDALINE | Middle: | Last: ELLINGER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mr. E. J. Habersack | Address: Cresaptown, Md. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARCINOMATOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 YRS

DUE TO, OR AS A CONSEQUENCE OF

(b): ADENOCARCINOMA of UTERUS — 16 YRS.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1829

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CEREBRAL VASCULAR ACCIDENT

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 1954 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Endometrial CA | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 1954, to JAN 24, 1971, that (I) (we) last saw the deceased alive an JAN 19 1971, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: [signature] MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 1-25-71

22d. PHYSICIAN'S NAME (Type): Donald B. Grove — 22e. ADDRESS: Cumberland, Md

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 1-27-1971 | 23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery | 23d. LOCATION (City or Town) (County) (State): Frostburg, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: Joseph R. Durst Sr. | ADDRESS: Frostburg, Md. | 25a. RECD BY REGISTRAR DATE: FEB 2 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the deoth certificate be executed within 24 hours after death. Page 4 moy be retoined by the hospital or attending physicion.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician ond completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — pages 1 and 2 should be filed with the State Dept. of Heolth prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00006 00006

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| SAMUEL | HARRISON | BERGMAN | 01 19 71 | 12:35P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 01-15-92 | 79 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Ret. Delliverygman | Brewery |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 520 FORESTER AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| James | H. | BERGMAN | SARAH | A. | LONG |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| YES W. W. # 1 | 214-05-4941 | HOSP.REC., | 900 SETON DR., CUMB., MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, MASSIVE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 DAY

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC AND CORONARY HEART DISEASE — 5 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical exominer) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 3-4, 19 66, to 1-19, 19 71, that (I) (we) last saw the deceased alive an 1-19 19 71, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Ru Brein | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 1-19-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| R.W.BALLIN, M.D. | 51 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| Burial | 1/22/71 | SS. Peter & Paul Cem. | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| H. Wayne George GEORGE'S FUNERAL HOME | Cumberland, Md. | JAN 25 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the deoth certificote be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event within 72 hours after death.

VR A15 (4) 25m-1/70

SAMUEL HARRISON BERGMAN 01 19 71 12:35P

MALE WHITE 01-15-02 79

MARYLAND USA X ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL Rev. Dr. Bergman Director

MARYLAND ALLEGANY CUMBERLAND X 520 FORESTER AVENUE

Lane J. BERGMAN SARAH A. LONG

YES W. M. 214-05-4941 HOSP.REC.,900 SETCHNNBR.,CUMB.,MD.21502

MYOCARDIAL INFARCTION, MASSIVE 1 DAY

ARTERIOSCLEROTIC AND CORONARY HEART DISEASE 5 YEARS

X

3 - 4 66 1 - 19 71

1 - 19 71

X 1-19-71

R.W.BALLIN, M.D. 51 GREENE ST., CUMBERLAND, MD. 21502

Burial 1/22/71 SS. Peter & Paul Cem. Cumberland, Allegany Md.

N. Wayne George

GEORGE'S FUNERAL HOME Cumberland, Md.

FOR STATE HEALTH DEPT.

00007

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00007

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with tarh Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Gladys | Middle: | Last: Bland | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month Day Year: Jan. 16, 1971 | 2b. HOUR: 45a M | | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: July 16, 1893 | 6. AGE (In years last birthday): 77 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN.: | 2c. DATE PRONOUNCED DEAD Month Day Year: January 16, 1971 | 2d. HOUR: 45a M |
| 7a. BIRTHPLACE (State or foreign country): England | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 210 Arch St. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 210 Arch St. | | | | | |
| 14. FATHER'S NAME First: Andrew | Middle: Mowe | Last: | 15. MOTHER'S MAIDEN NAME First: Lena | Middle: Rutledge | Last: | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Arthur B land, Cumberland, Md. Son | | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Sclerosis — ----
DUE TO, OR AS A CONSEQUENCE OF
(c):
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: January 16, 1971
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 18, 1971 | Hillcrest Burial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JAN 21 1971 | Vernon R. Randall |

VR A15ME (5) 10M - 1/69

1

00008

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00008

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: TRACEY Middle: LYNANN Last: BREHM | 2a. DATE OF DEATH Month: JAN Day: 23 Year: 71 | 2b. HOUR: 7:15 PM | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 11-15-68 | 6. AGE (In years last birthday): 2 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None | 12b. KIND OF BUSINESS OR INDUSTRY: None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ X | 13e. STREET AND NUMBER: 713 HILLTOP DRIVE |
| 14. FATHER'S NAME First: EUGENE Middle: M. Last: BREHM | 15. MOTHER'S MAIDEN NAME First: JUDITH Middle: A. Last: HOENICKA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: None | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

465X

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Electrolyte Imbalance + Dehydration | 24 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Bronchopneumonia | 24 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Upper Respiratory Infection | 24 hrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 1971, to Jan 23, 1971, that (I) (we) last saw the deceased alive on Jan 22 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Lester Rufer MD, HWE. DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ | | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type): H.W. ELIASON | 22e. ADDRESS: 203 GREEN ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Jan.26,1971 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery |
| 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: JAN 28 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1

00009

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00009

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
| FRANK | E. | BROTEMARKLE | 1-29 71 | 10:20 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 4-5-00 | 70 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Disabled | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | | 208 E. INDUSTRIAL BLVD. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ANDREW | | BROTEMARKLE | ALLA | | WILSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | | 214-05-9337 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Lung Cancer, right, c | 4 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Pneumonia | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Pneumonia Primary Tract Infection Carcinoma of Lung | 20 yrs |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1870

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1/18, 19 71, to 1/29, 19 71, that (I) (we) last saw the deceased alive on 1/29 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | | | | 1 Feb 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. S.G.WEISMAN | CUMBERLAND MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 2/ 1/1971 | Rose Hill Cemetery | Cumberland Alleg Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. FILED BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hafer Funeral Service, 230 Balto Ave. Cumberland, Md | | FEB 3 1971 | Vernon R. Randall |

VR A15 (4) 25m-1/70

1
FOR STATE HEALTH DEPT.

00010

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00010

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18/Give Pages 1 & 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MV Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Jay | Middle: Martin | Last: Catlett | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 1 Day: 23 Year: 71 19 | 2b. HOUR: 8:20 A.M. | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: July 15, 1918 | 6. AGE (In years last birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month: January Day: 23 Year: 1971 | 2d. HOUR: 8:20 A.M. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Meter Reader | 12b. KIND OF BUSINESS OR INDUSTRY: Gas Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 100 Wempe Drive | |
| 14. FATHER'S NAME First: Frank | Middle: | Last: Catlett | 15. MOTHER'S MAIDEN NAME First: Rosetta | Middle: | Last: Martin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): War II | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Frances Catlett | ADDRESS: Cumberland, Md. | Wife | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Thrombosis — "

DUE TO, OR AS A CONSEQUENCE OF

(c): Coronary Sclerosis — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 23, 1971

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Jan. 26, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR DATE: JAN 28 1971 | 25b. REGISTRAR'S SIGNATURE: James G. Randall | |

VR A15ME (5) 10M - 1/69

1
FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

00011

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00011

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month Day Year | 2b. HOUR |
|---|---|---|---|---|---|
| Catherine | | Cifala | X | Jan. 11 1971 | 5A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | Feb.2,1882 | 88 YRS. | | | | | Jan. 11 1971 | 11A M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Italy | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 405 Prince George St. | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 405 Prince George St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Joseph (Stephen) | | Aloisi | Stefana | D'Arrigo | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | | Mr. Lacy B. Cifala, Cumberland, Md.-Son |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS — *******

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b. DATE SIGNED Jan.11,1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan.14,1971 | SS. Peter & Paul Cem. | Cumberland, Md. Allegany |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JAN 15 1971 | Simon P. Randall |

3 1

00012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00012

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| HELEN | J. | CONNER | 1 | 10 | 71 | 8:05PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 7-26-20 | 50 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | USA | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | USA | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 224 N. MECHANIC ST |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Harry | Ellsworth | SMEAK | Lilly Anna (Poorbaugh) Smeak | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 215-20-6695 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | | | | 1/11/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. B. SCHINDLER PA | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan.13,1971 | Hyndman Kemetery | Hyndman, Bedford Co,mPa. 15545 |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, Pa. 15545 | JAN 15 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00013 00013

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| NANNIE | MAE | CROWE | 01 07 71 | 11:20 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 07-28-13 | 57 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART | HWF. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | ROUTE 1, BOX 535 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | | ARNOLD | ELLEN | | MEESE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | NONE | HOSPITAL RECORD, SACRED HEART HOSPITAL |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | congestive heart failure | 1 week |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertensive disease | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Coronary sclerosis | 1 year |

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

diabetes

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| L. Brings | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 1-8-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| LEWIS BRINGS, M.D. | 57 GREENE STREET, CUMBERLAND, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JAN. 9, 1971 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD. | JAN 13 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

1
FOR STATE HEALTH DEPT.

DOO14

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00014

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMC Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Olive | Middle: Pearl | Last: Davis | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: 1-17-71 Doy: Year: 19 | 2b. HOUR: 3pM | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: May 22, 1899 | 6. AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month: January Doy: 17 Year: 1971 | 2d. HOUR: 4p M | | |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Oldtown, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route 1 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Oldtown | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Route 1 | | | |
| 14. FATHER'S NAME First: Lionel | Middle: M. | Last: Piper | 15. MOTHER'S MAIDEN NAME First: Emma | Middle: M. | Last: Moreland | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Charles E. Davis | ADDRESS: Oldtown, Md.-Husband | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Occlusion | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | — |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: Jan 17, 1971
ADDRESS (Street, city, town, or county): Rt. 9, Cumberland, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Jan. 20, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Oliver Grove Cemetery | 23d. LOCATION (City or Town) (County) (State): Oldtown, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: JAN 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15ME (5)
10M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

00015

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00015

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | 2b. HOUR |
|---|---|---|---|---|
| BURLAND | E. | DeBOLT | JAN. 2, 1971 | 7A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARCH 3, 1904 | 66 YRS. | | | | | JAN. 2, 1971 | 7:30A M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | DOA MEMORIAL HOSPITAL | LINOTYPE OPERATOR | NEWSPAPER |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [ ] NO [X] | 2019 BEDFORD ROAD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | | DeBOLT | NELLIE | | McCRAY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | 214 05 6964 | MRS. BEULAH DeBOLT CUMBERLAND, MD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street or R.F.D., town or city, county) CUMBERLAND, MARYLAND

22b. DATE SIGNED JAN. 2, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JAN. 5, 1971 | SUNSET MEMORIAL PARK | CUMBERLAND, MARYLAND |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | JAN 6 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Complete Pages 1 and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00016 00016

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HENRIETTA | M. | DODDS | 01 27 71 | 5:40 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 03 14 06 | 64 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED XX / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | LONACONING | YES X NO | DETMOLD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ROBERT | | MOFFATT | (SOURBRINE) MARTHA | | MOFFATT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|---|
| NO | | 219-44-2378 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | METASTATIC ADENO CARCINOMA | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CA of BREAST c METASTASIS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ASCVD c CHF | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO X | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 1-17, 1971, to 1-27, 1971, that (I) (we) last saw the deceased alive on 1-26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| M. Kaufman MD | MD | ✓ | | | 1-28-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| M. KAUFMAN, M.D. | 924 SETON DR., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/29/1971 | Oak Hill Cemetery | Lonaconing, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| EICHHORN FUNERAL SER., 8 MAIN ST., LONACONING, | MD. 21539 | FEB 1 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top copy papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25m-1/70

00017

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00017

## CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| RAY | GUINARD | DONALDSON | JANUARY 11 1971 | 12 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | Caucasian | October 2, 1901 | 69 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of warking life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Rural | Rt 4 Box 345 Cumberland | Salesman | Retail |

| 13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [ ] NO [X] | Rt. 4 Box 345 Cumberland |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Solomon | | Donaldson | Rachel Lewis | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | W.W. II | 217-10-7668 | Mrs. Marie S. Donaldson | Rt.4 Box 345 Cumberland 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchiogenic Adenocarcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO, OR AS A CONSEQUENCE OF

Conditians, if any, which gave rise to immediate cause (a), stoting the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at wark [ ] Nat while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street ar R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 11/3, 1970, ta 1/11, 1971, that (I) (we) last saw the deceased alive an 11/3 1970, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the bady after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED |
|---|---|---|
| J.A. Pagan | | 1/11/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| J.A. Pagan, M.D. | 1068 National Highway LaVale, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 14, 1971 | Sunset Memorial Park | Near Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John J. Hafer Jr. Hafer Funeral Service | Cumberland, Md. | JAN 14 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carbon paper, Pages 1 and 2 should be filed with the State Dept. af Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

00018

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00018

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2o. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Ann | E. | Dorsey | 1 28 71 | 10:10 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In yeors lost birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | 5/17/'85 | 85 YRS. | | |

| 7o. BIRTHPLACE (Stote or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va | America | | Allegany, County, Md. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, Md. | Lions Manor Nursing Home | Society Editor (Retired) | Cumb. Times |

| 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | | [redacted] |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Thomas | | Dorsey | Katherine | | Cruise |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give wor or dotes of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | | 220-10-9327 | Daniel F. McMullen Jr. | First Fed. Bldg. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ATERIOSCLEROTIC CARDIO-VASCULAR DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 YEARS

4124

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

CEREBRAL SCLEROSIS

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22o. **I certify** thot (I) (this hospitol) ottended the deceosed from 1 - 2, 49 69, to 1 - 28, 19 71, that (I) (we) last saw the deceased alive an 1 - 28 19 71, and that in (my) (aur) opinion death occurred on the date ond haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Ralph W. Ballin M.D | | ☒ | ☐ | ☐ | 1-29-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| RALPH W. BALLIN, M.D. | 51 GREENE ST. CUMBERLAND, MD. 21502 |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (Stote) |
|---|---|---|---|---|---|
| Burial | 2/1/1971 | Sts. Peter & Paul's Cath | Cumberland | Alleg | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. RECD BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles E. Hafer | Hafer Funeral Service, 230 Balto Ave. Cumberland Md | FEB 3 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
30M REV. 1/68

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH

00019

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00019

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| Clarkson | E. | Dunn |

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Day Year: 1/10/1971 — 2b. HOUR: 1-30 A.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | 10/5/1921 | 49 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month Day Year: January 10, 19 71 — 2d. HOUR: 6 a.M.

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Lonaconing | Jackson Street | Retired | Kelly Tire Co |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | Allegany | Lonaconing | YES [X] NO [ ] | Jackson St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Clarkson | | Dunn | Goldie | | Kisner |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | War # 2 | | Mrs. Marie Dunn (WIFE) | Cumberland, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Occlusion | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gove rise to immediate cause (a). stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Manth, Day, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, affice building, etc.) | 21f. LOCATION Street ar R.F.D. No. | City ar Tawn | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy [ ], Inspection [X] Inquiry [X], ond in my opinion deoth resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 10, 1971

ADDRESS(Street, city, town, county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| 1/13/1971 | Burial | Memorial Park | Frostburg, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George Eichhorn | Lonaconing, Md. | JAN 13 1971 | Florence A. Randall |

Item #4 Film #G433
2/2/71 pcs
00020

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00020

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Clarkson | E. | Dunn | 1 | 22 | 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | ~~Race~~ White | 4/11/1892 | 78 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA. | MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg | Miners Hospital | Retired | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | Allegany | Lonaconing | YES X NO | Jackson St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Unknown | | | Sarah | Dunn | McKenzie |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | Mrs. Goldie Dunn, Lonaconing, MD. (WIFE) |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute pneumonitis | 24 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Pulmonary Fibrosis | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchial Asthma - Acute urinary retention

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 1956, to 1-22, 1971, that (I) (we) last saw the deceased alive on 1-21 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L.R. Miles MD | MD | | X | | 1-22-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L.R. MILES JR MD | LONACONING, MD 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/25/1971 | Memorial Park | Frostburg, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George Eichhorn | Lonaconing, Md. | JAN 25 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00021

# CERTIFICATE OF DEATH

00021

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| DELLA | CHRISTINE | ELKINS | 1 10 71 | 2:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | DEC 3, 1902 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | USA | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | Mineral | RIDGELEY | YES X NO | 95 KNOBLEY ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ROBERT | A. | KINCAID | ANNIE | Belle | MENTZ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 215-26-9833 | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myelocytic leukemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 wks
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 12-28, 1970, to 1-10, 1971, that (I) (we) last saw the deceased alive on 1-9-71 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William P James | | X | | | 1-13-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. P. JAMES | 141 N. CENTRE ST. CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 13, 1971 | St. Patrick's Cemetery | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George Cumberland, Md. | JAN 18 1971 | Vernon R. Riddell |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00022 00022

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EARL | Middle: THEODORE | Last: EMERICK | 2a. DATE OF DEATH Month 01 Day 07 Year 71 | 2b. HOUR 2:40 M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 07 02 83 | 6. AGE (In years last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY COUNTY, Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CELANESE FIBERS CORPORATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNA. | 13b. COUNTY | 13c. CITY OR TOWN: HYNDMAN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: RT. #1, HYNDMAN, PENNA. | |
| 14. FATHER'S NAME First: JOSEPH | Middle | Last: EMERICK | 15. MOTHER'S MAIDEN NAME First: (THARP) ANNA | Middle: ( Burns ) | Last: EMERICK |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No | 16b. SOCIAL SECURITY NO.: 217-10-5487 | (If yes give war or dates of service) | 17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | Address: MD. 215 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I **certify** that (I) (this hospital) attended the deceased from 12-29, 19 70, to 1-7, 19 71, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: W F Speagle | DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] | 22c. DATE SIGNED: 1-9-71 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS: Cumberland, Md. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: January 10, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Cooks Mills Cemetery | 23d. LOCATION (City or Town) (County) (State): Hyndman, RD#1, Bedford Co., Pa. | |
| 24. FUNERAL DIRECTOR: ZIEGLER FUNERAL HOME, HYNDMAN, PENNA. | ADDRESS: 15545 | 25a. REC'D BY REGISTRAR DATE: JAN 13 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4)
25m-1/70

00022

EARL THEODORE EMERICK 01 07 71 2:40

MALE WHITE 07 02 83 87

XX

PENNSYLVANIA U.S.A. ALLEGANY COUNTY,

CUMBERLAND SACRED HEART HOSPITAL CELANESE FIBERS CORPORATION

PENNA. HYNDMAN RT. #1, HYNDMAN, PENNA.

JOSEPH . EMERICK (THARP) ANNA ( Burns) EMERICK

MD. 21

No 217-10-5487 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,

Cumberland, Md. 21502

Burial January 10,1971 Cooks Mills Cemetery Hyndman, RD1, Bedford Co.,Pa.

15545

ZIEGLER FUNERAL HOME, HYNDMAN, PENNA.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00023 (upper left) 00023 (upper right)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: VERA | Middle: M | Last: EVANS | 2a. DATE OF DEATH: Month 1 Day 3 Year 71 | 2b. HOUR: 2:10 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 8-12-95 | 6. AGE (In years last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY COUNTY, Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife, | 12b. KIND OF BUSINESS OR INDUSTRY: Own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 7 VIRGINIA AVENUE | |
| 14. FATHER'S NAME First: DANIEL | Middle | Last: TRUTLE | 15. MOTHER'S MAIDEN NAME First: FLORENCE | Middle | Last: HEAVNER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service): No, | 16b. SOCIAL SECURITY NO.: 170-11-8252 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MARYLAND | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis from — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO, OR AS A CONSEQUENCE OF

(b): Carcinoma - head of pancreas

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: August 70 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of head of pancreas | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS DR CONTRIBUTING [ ] (If either, notify medical examiner) UNDERLYING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that (I) (this hospital) attended the deceased from August, 1970, to Jan 3, 1971, that (I) (we) last saw the deceased alive on Jan 2 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Thomas J Lewis M.D. DEGREE | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 1/3/71 | |
| 22d. PHYSICIAN'S NAME (Type): DR. T. F. LEWIS | 22e. ADDRESS: GREENE STREET CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/6/71 | 23c. NAME OF CEMETERY OR CREMATORY: Green Ridge Memorial Park | 23d. LOCATION (City or Town): Nr. Scottdale | (County): Westmoreland, Pa. (State) |
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: 202 Greene St. Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: JAN 6 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00024 00024

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| GEORGE | WESLEY | EVERLY | JANUARY 31, 1971 | 12:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 04-15-83 | 87 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Clerk | A & P MARKET |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 12 BOONE STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JEREMIAH | | EVERLY | (MC NEW) ANNIE | | EVERLY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214-05-8620 | HOSP. RECORD-900 SETON DRIVE, CUMB. MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Resp Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease 2 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus unknown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of Prostate & Angina

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / DR CONTRIBUTING | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospitol) ottended the deceased from 1-30, 19 71, to 1-31, 19 71, that (I) (we) lost saw the deceased olive on 1-31 19 71, and that in (my) (our) opinion deoth occurred on the dote and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| J.A. Pagan | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 2/1/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| J.A. PAGAN M.D. | 1068 NATIONAL HWY., LA VALE, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Feb. 3, 1971 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SCARPELLI FUNERAL HOME | 108 VIRGINIA AVE. CUMBERLAND, MD. 21502 | FEB 5 1971 | Vernon F. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1
FOR STATE HEALTH DEPT.

00025

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00025

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: William | Middle: Owen | Last: Fansler | 2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month: Jan. Day: 1, Year: 1971 |
| 2b. HOUR: 1:00 A.M. | 2c. DATE PRONOUNCED DEAD Month: Jan. Day: 1, Year: 1971 | 2d. HOUR: 1:00 A.M. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: July 11, 1881 | 6. AGE (In years last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (State or foreign country): W. Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH: Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Ret. Track Foreman | 12b. KIND OF BUSINESS OR INDUSTRY: W. Md. Rwy. |

| | | | | |
|---|---|---|---|---|
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. Va. | 13b. COUNTY: Mineral | 13c. CITY OR TOWN: Ridgeley, | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Miltenberger Rd. Rt. # 1 Box 36, |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME First: John | Middle: S. | Last: Fansler | 15. MOTHER'S MAIDEN NAME First: Alice / Middle: J. / Last: Gibson |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 705-12-2038 | 17. INFORMANT: Mrs. Mary H. Fansler | ADDRESS: Rt. # 1 Ridgeley, W. Va. Box 36, |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): BRONCHO PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4121

DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c): ASHD, HCVD & CORONARY ARTERY DISEASE & DECOMPENSATION 10 Yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Medial compression fracture 10 th. dorsal vertebral body

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |

| | | | |
|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 8:30 12/21 1970 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell off chair while changing light bulb | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Porch of residence | 21f. LOCATION Street or R.F.D. No.: Miltenberger Rd. Rt. # 1 Ridgeley, | City or Town: Mineral County: W. Va. State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Rt. # 9 Cumberland, Md

22b. DATE SIGNED: Jan. 2, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/4/71 | 23c. NAME OF CEMETERY OR CREMATORY: Day Cemetery, | 23d. LOCATION (City or Town): Bowden, | (County): Randolph, (State): W. Va. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: 202 Greene St. Cumberland, Md. 21502 | 25a. REC'D BY REGISTRAR DATE: JAN 6 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall |

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00026

00026

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: DANIEL | Middle: J | Last: FOLK | 2a. DATE OF DEATH: JAN Month 14 Day 71 Year | 2b. HOUR: 3:10 P M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-9-01 | 6. AGE (In years last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: FARMING | | |
| 13a. USUAL RESIDENCE (Where deceased lived / if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: GARRETT | 13c. CITY OR TOWN: GRANTSVILLE | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First: WILSON | Middle | Last: FOLK | 15. MOTHER'S MAIDEN NAME First: ARMINTO | Middle | Last: OTTO |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-36-9407 | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute pulmonary insufficiency | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Advanced pulmonary emphysema | 6 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | chronic asthmatic bronchitis | 20 yrs |

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebral anoxia. myocardial ischemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1-4, 1971, to 1-14, 1971, that (I) (we) last saw the deceased alive on 1-14 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. V Dross DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 1-15-71

22d. PHYSICIAN'S NAME (Type): DR. V. DROSS MA

22e. ADDRESS: CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 1/17/71 | Casselman Menn. Ch. Cem. | Grantsville, Garrett, Md. |

24. FUNERAL DIRECTOR ADDRESS: Don F Neaman Grantsville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 1971

25b. REGISTRAR'S SIGNATURE: Vernon B Randall

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00027

# CERTIFICATE OF DEATH

00027

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Rhoda | V | Garlitz | Jan 27 1971 | 5:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | 4-26-88 | 82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U. S. A. | WIDOWED [X] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Lion's Manor N.H. | Housewife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Frostburg | YES [ ] NO [ ] | Rt 2, Box 572 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | A. | Robison | Fannie | | Blocher |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 217-48-3483 | Raymond Garlitz Rt 2, Frostburg, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Biliary Tract — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1569

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** thot I (this hospitol) attended the deceased from 01-14, 19 71, to 01-27, 19 71, thot I (we) last saw the deceased olive an 01-27 19 71, and thot in my (our) opinian death occurred on the date and haur and fram the couses stoted above, (I) (~~we~~) (~~did~~) (did not) view the body after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Victor Mazzaco | | [X] | [ ] | [ ] | 01-27-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| VICTOR MAZZACO, M. D. | 312 Seton Drive, Cumberland, Md. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 30, 1971 | Blocher Cemetery | Garrett County, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Joseph R. Durst, Sr., Frostburg, Md. 21532 | FEB 3 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

00023

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: ETHEL | Middle: A. | Last: GROTER | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 1 Day: 23 Year: 1971 | | 2b. HOUR: 10:28PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 07-07-91 | 6. AGE (In years last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month: JANUARY Day: 23, Year: 1971 | 2d. HOUR: 10:28PM |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED DOMESTIC | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: FROSTBURG | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: MESHACH FROST VILLAGE | |
| 14. FATHER'S NAME First: REED | Middle: | Last: ANDERSON | 15. MOTHER'S MAIDEN NAME First: VIOLA | Middle: | Last: ANDERSON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 171-30-2884-A | 17. INFORMANT ADDRESS: ROBT. GROTER, MONROEVILLE, PA. 15146 | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Days
4122
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertensive Cardiovascular Disease --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: January 23, 1971
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: JAN. 26, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK | 23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD. | |
| 24. FUNERAL DIRECTOR ADDRESS: DURST FUNERAL HOME, FROSTBURG, MD. 21532 | | 25a. REC'D BY REGISTRAR DATE: JAN 28 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00029 00029

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Wayne | Middle: Frederick | Last: Herpich | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: Jan. | Day: 13 | Year: 1971 | 2b. HOUR: 10:20 A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Nov. 9, 1931 | 6. AGE (In years last birthday): 39 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month: January | Day: 13 | Year: 1971 | 2d. HOUR: 10:20 A M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: La Vale | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: 9 Asbury Avenue | | | |
| 14. FATHER'S NAME First: Carl | Middle: W. | Last: Herpich | 15. MOTHER'S MAIDEN NAME First: Gerdia | Middle: | Last: Butler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-42-4373 | 17. INFORMANT: Cumberland, Md. ADDRESS (Trustees) Rev. B. Finney Bragg & Rob't M. Herrell, Sr. | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF
(b): Status epilepticus — ----
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3452

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: January 13, 1971
ADDRESS (Street, city, town, or county)

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/17/1971 | Sunset Memorial Park | Nr. Cumberland Alleg Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles E. Hafer Hafer Funeral Service, 230 Balto Ave. Cumberland Md | JAN 18 1971 | Vernon P. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00030

00030

FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Janet | Middle: | Last: Hunter | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Doy Yeor: 1-30-71 | 2b. HOUR: 2:33 a M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Feb. 29, 1904 | 6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month Doy Yeor: January 30, 1971 | 2d. HOUR: 2:33a M |
| 7a. BIRTHPLACE (State or foreign country): Scotland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Sacred Heart Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Lonaconing | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: Church Street | |
| 14. FATHER'S NAME First: James | Middle: | Last: Wallace | 15. MOTHER'S MAIDEN NAME First: Henrietta | Middle: | Last: Main |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 300-01-9373 | 17. INFORMANT: Edward Hunter, Husband | ADDRESS: Same | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: "

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: -----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** thot I took charge of the remoins described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion deoth resulted from: Natural couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE: Benedict Skitarelis M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 30, 1971

ADDRESS(Street, city, town, county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 2/1/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery | 23d. LOCATION (City or Town) (County) (State): Lonaconing, Md. | |
| 24. FUNERAL DIRECTOR: Eichhorn Funeral Home | ADDRESS: Lonaconing, Md. | 25a. REC'D BY REGISTRAR DATE: FEB 2 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

D0031

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00031

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Edward | Francis | Joyce | ☒ / ☐ | Jan. | 13, | 1971 | 3:30 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | Oct. 4, 1893 | 77 YRS. | | | | | Jan. | 13. | 19 71 | 3:30 P.M. |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U. S. A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, | Sacred Heart Hosp. | Ret. Millwright | Celanese Corp |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland, | YES ☒ NO ☐ | 644 Fayette St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Patrick | -- | Joyce | Anna | -- | Donahue |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No, | 214-07-6392 | Mrs. Agnes B. Joyce 644 Fayette St. Cumb. Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis — ----

DUE TO, OR AS A CONSEQUENCE OF (c) ASCV Disease — ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Emphysema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Rt. # 9 Cumberland, Md.

22b. DATE SIGNED Jan. 15, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/16/71 | SS. Peter & Paul Cem. | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | JAN 18 1971 | Thomas E. Rudasill |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1
FOR STATE HEALTH DEPT.

00032

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00033

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: John | Middle: Christopher | Last: Koegel | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: Jan. 16, 1971 | 2b. HOUR: 8:45 A.M. | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 6-24-83 | 6. AGE (In years last birthday): 87 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 19: January 16, 1971 | 2d. HOUR: 8:45a M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany | | Md. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED-TAX COLLECTOR | 12b. KIND OF BUSINESS OR INDUSTRY: CITY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Frostburg | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 70 S. Water Street | |
| 14. FATHER'S NAME First: JOHN | Middle | Last: KOEGEL | 15. MOTHER'S MAIDEN NAME First: CATHERINE | Middle | Last: ZINK |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217-30-1309 | 17. INFORMANT ADDRESS: MRS. MILDRED HENDERSON, FREDERICK, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism — Approximate Interval Between Onset and Death: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Fracture of Right Hip — 2 Days

DUE TO, OR AS A CONSEQUENCE OF

(c):

8851

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old Myocardial Infarctions; Codonary Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: Jan. 15, 1971 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?: Open reduction & pinning right hip | 20. AUTOPSY? YES [X] NO [ ] | |
| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 10am 1-14-71 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell on ice | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home | 21f. LOCATION Street or R.F.D. No. City or Town County State: 70 S. Water St. Frostburg, Alleg. Maryland | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 16, 1971

ADDRESS (Street, city, town, or county):

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 1-18-1971 | 23c. NAME OF CEMETERY OR ~~CREMATORY~~: FROSTBURG MEMORIAL | 23d. LOCATION (City or Town) (County) (State): FROSTBURG ALLEG. MD. | | |
| 24. FUNERAL DIRECTOR: Durst | ADDRESS: Joseph R. Durst Frostburg, Md. | 25a. REC'D BY REGISTRAR DATE: JAN 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon B. Randall | | |

VR A15ME (5)
10M - 1/69

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00033

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00034

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First JOSEPH Middle Peter Last KOTSCHENREUTHER | 2a. DATE OF DEATH 1 - Month 18 Day 71 Year | 2b. HOUR 8:25 P M | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH 5-17-86 | 6. AGE (In years last birthday) 84 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lunchroom Prop. | 12b. KIND OF BUSINESS OR INDUSTRY Restaurant |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | 13b. COUNTY ALLEGANY | 13c. CITY OR TOWN LAVALE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER 102 WEIGAND DR |
| 14. FATHER'S NAME First George Middle -- Last Kotschenreuther | | 15. MOTHER'S MAIDEN NAME First Catherine Middle -- Last Seiss | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. 219-03-9046 | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ischemic Heart Disease

4123

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Parkinsonism

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan, 1964, to Jan 18, 1971, that (I) (we) last saw the deceased alive on 1/18 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE William P. Iames, MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 1/20/71 | |
| 22d. PHYSICIAN'S NAME (Type) DR. W.P. IAMES | 22e. ADDRESS CUMBERLAND, MD. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1/21/71 | 23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem. | 23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md. |
| 24. FUNERAL DIRECTOR ADDRESS H. Wayne George 202 Greene St. Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE JAN 25 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00034

# CERTIFICATE OF DEATH

00035

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|
| FRANKLIN | C. | LANE | 01 Month 03 Day 71 Year | 5:00AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 1/6/28 | 42 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| NEW YORK | U.S.A. | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | TEACHER - FROSTBURG STATE COLLEGE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | BISHOP WALSH ROAD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| FRANK | C. | LANE | (BADENHOP) BERTHA | B. | LANE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 088 20 9009 | PATIENT'S HOSPITAL CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic melanoma. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Mos

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 12/25, 1970, to 1/1, 1971, that (I) (we) last saw the deceased alive on 12/31 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | M D | | X | | 5 Jan 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/6/71 | Hillcrest Burial Pk. | Cumberland, Allegany MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| STEIN'S FUNERAL HOME, 117 FREDERICK ST., CUMB. | MD. 21502 | JAN 11 1971 | Vernon R. Rudd |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT3 (4) 25m-1/70

00034

00035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00035 — 00036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it with the local registrar. Then please remove carbon papers, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| GENEVIEVE | E | LEASURE | JAN 2 1971 |

2b. HOUR: 10:50 A

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 6-13-18 | 52 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSE WIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | X | 605 LEIPER ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| RANDOLPH | B. | HARTLEY | NELA [redacted] | | ALT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| NO | | 215-20-5327 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Refractory Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 month
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Disease — years
DUE TO, OR AS A CONSEQUENCE OF
(c)

4124
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus, Raynauds Disease, Hypothyroidism

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 8-29-70 19____, to 1-2-71 19____, thot (I) (~~we~~) last saw the deceased olive on 1-2-71 19____, and that in (my) (~~our~~) opinion deoth occurred an the dote and hour and from the causes stoted abave, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 1-4-70

22d. PHYSICIAN'S NAME (Type): G.O. HIMMELWRIGHT, M.D.
22e. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JANUARY 5, 1971 | GLENDALE CEMETERY | FLINTSTONE ALLEGANY MARYLAND |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND, MD. | JAN 13 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

00036

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00037

| 1. DECEASED-NAME (Type or Print) | First | Middle | Last |
|---|---|---|---|
| | Ethel | Mae | Livingood |

2a. DATE KNOWN ☐ OF DEATH ESTIMATED ☐ Month Jan. Day 14 Year 1971 — 2b. HOUR 4 A M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| Female | White | Aug. 30, 1894 | 76 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month Jan. Day 14 Year 1971 — 2d. HOUR 4A M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Penna. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 207 New Hampshire Ave. | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 207 New Hampshire Ave. |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Scott Welsh | Belle Casteel |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Husband Mr. Clarence Livingood, Cumberland, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

(b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Rt. 9 Cumberland Md.

22b. DATE SIGNED Jan. 14, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 16, 1971 | Davis Memorial Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JAN 21 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MB. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

FOR STATE HEALTH DEPT.

00037

MARYLAND STATE DEPARTMENT OF HEALTH

00038

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Nancy | L | Llewellyn | 1-12-71 19 | 11p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Female | White | July 28,1951 | 19 YRS. | | | January 12, 1971 | 11p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USa | MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Secretary | Hospital |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W.Va | Hampshire | Springfield | YES ☐ NO X | Rural |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Vernon | R. | Mulligan | Jean | C. | Landis |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 233-84-1290 | John M. Llewellyn, | Springfield, W,Va. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Subdural Hemorrhage, — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO, OR AS A CONSEQUENCE OF (b) Skull Fracture — " 

DUE TO, OR AS A CONSEQUENCE OF (c)

8160

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 9:45 1-12-71 | Driver of Car-Lost control on Ice |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Route #28 W.Va. | Three miles North Romney,Hampshire,W.Va |

22a. **I certify** that I took charge of the remains described above, held an Autopsy XX Inspection XX Inquiry XX, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED January 12, 1971

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/15/71 | Springfield Hill Cem. | Springfield Hampshire W,Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD. BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| [signature] | Romney, W,Va. | JAN 18 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

1

00038

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00039

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: MELVIN Middle: J Last: MALCOLM | 2a. DATE OF DEATH Month: 01 Day: 29 Year: 71 | 2b. HOUR: 2:50 A M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 6-16-03 | 6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Bottling Dept. | 12b. KIND OF BUSINESS OR INDUSTRY: Brewery |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.VA. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: PAW PAW | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: RT 1, BOX 114 (LIVES IN MD) | | | |
| 14. FATHER'S NAME First: JACOB Middle: Last: MALCOLM | 15. MOTHER'S MAIDEN NAME First: BETTY Middle: Last: COX | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 212-28-1635 | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: 185X

IMMEDIATE CAUSE (a) Renal failure & Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma prostate

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs +

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 1/21/, 1971, to 1/29/, 1971, that (I) (we) last saw the deceased alive on 1/28/ 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Walter N. Himmler | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 1/30/71 |
| 22d. PHYSICIAN'S NAME (Type): DR. W.N. HIMMLER | 22e. ADDRESS: CUMBERLAND, MD. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Jan.31,1971 | 23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel | 23d. LOCATION (City or Town) (County) (State): Three Churches, W.Va. |
| 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: FEB 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00039 00040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| EDITH | F. | MANGES | 01 | 17 | 71 | 12:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | 11-03-14 | 56 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE - HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 907 MICHIGAN AVE., CUMB., |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | W. | FISHER | (GRAYSON) WILLA | MAE | FISHER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic, Cerebral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Adenocarcinoma of the breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING? (If either, notify medical examiner) | UNDERLYING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Clarence J. Vincent M.D | | [X] | [ ] | [ ] | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| C. VINCENT, M.D. | 924 SETON DR., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 20, 1971 | Hillcrest Burial Park MD. | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SCARPELLI FUNERAL HOME, | VIRGINIA AVE., CUMB., | JAN 21 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

2 1

00040

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00041

## CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| EMMA | E. | MARTENS | JAN. 25 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | JANUARY 23, 1891 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | HOUSE WIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES ☒ NO ☐ | 93 WASHINGTON ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | W. | TRESSLER | ANNIE | | BITTNER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | FRANKLIN MARTENS, FROSTBURG, MD. 21532 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized Arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1965, to 1-25, 1971, that (I) (we) last saw the deceased alive on 1-25 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | MD | ☒ | ☐ | ☐ | 1-27-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| LESLIE R. MILES, M. D. | STATE ST., LONACONING, MD. 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JAN. 28, 1971 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | FEB 1 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

00041

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00042

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ESTHER | Virginia | MAXSON | 1 29 71 | 10:05 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 6-14-15 | 55 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | USA | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Clerk | Grocery Store |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | Mineral | RIDGELEY | YES / NO X | Frankfort Rd. RT. #1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | | ROBINSON | NELLIE | | DUCKWORTH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No. | | | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS

4330

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

HYPERTENSIVE VASCULAR DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES X NO | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH | HOUR A.M. P.M. Month Day Year 19 | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| While at work / Not while at work | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1/28, 19 71, to 1/29, 19 71, that (I) (we) last saw the deceased alive on 1/29 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Renato N Espina | | X | | | 1/30/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. RENATO ESPINA | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 2/1/71 | Maplewood Cemetery | Elkins, Randolph W. Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | FEB 3 1971 | Vernon O. Randall |

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

00042

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00043

1. DECEASED-NAME (Type or Print): First: Albert; Middle: --; Last: McCoy

2a. DATE KNOWN OF ESTIMATED DEATH: ☒ Month: Jan. Day: 2, Year: 1971

2b. HOUR: 9 A.M.

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: 6/25/84

6. AGE (In years last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 24 HRS.: HOURS: MIN:

2c. DATE PRONOUNCED DEAD: Month: Jan. Day: 2, Year: 19 71

2d. HOUR: 9 A.M.

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Cumberland,

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): DOA------ Memorial Hosp.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Ret. Farmer

12b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland,

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: Rt. # 2 Williams Rd.

14. FATHER'S NAME: First: William; Middle: ; Last: McCoy

15. MOTHER'S MAIDEN NAME: First: Alice; Middle: J.; Last: Hymes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 220-52-9854

17. INFORMANT: Mrs. Alma M. Kisamore, Rt. # 2 Box 357A ADDRESS: Cumberland, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS(Street, city, town, or county): Rt. # 9 Cumberland, Md.

22b. DATE SIGNED: 1/2/71

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1/5/71

23c. NAME OF CEMETERY OR CREMATORY: McCoy Cemetery,

23d. LOCATION (City or Town) (County) (State): Polish Mt. Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: 202 Greene St. Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JAN 6 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours, after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00043 00044

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): First: William; Middle: C.; Last: McKee
2a. DATE OF DEATH: Month: 1; Day: 23; Year: 71
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 12/26/1901
6. AGE (In years last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Md
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Frostburg
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miners Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Celanese Corp
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Allegany
13c. CITY OR TOWN: Frostburg
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Wood Street
14. FATHER'S NAME First: James Last: McKee
15. MOTHER'S MAIDEN NAME First: Clara Middle: Last: Whitefield
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: "Sister" Address: Mrs. Earnest Smith Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Advanced Arteriosclerotic CVD — 5 yrs
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Fibrosis and Chronic Pulmonary insufficiency

19a. DATE OF OPERATION: NONE
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☒
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1970, to 1-23, 1971, that (I) (we) last saw the deceased alive on 1-22 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin M. Rothstein DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 1-23-71
22d. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D.
22e. ADDRESS: 48 BROADWAY - FROSTBURG - MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/25/71
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Lonaconing A. Md

24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: JAN 26 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers). Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00044 00045

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HELEN | Middle: B. | Last: MC KENZIE | 2a. DATE OF DEATH Month: JAN. Day: 22 Year: 71 | 2b. HOUR: 1:45 P M | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 07-18-37 | 6. AGE (In years last birthday): 33 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSP. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housekeeper- At Home | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: RT. 6 BOX 364 | | | |
| 14. FATHER'S NAME First: PATRICK | Middle: O. | Last: MC GREEVY | 15. MOTHER'S MAIDEN NAME First: (BYRNE) AGNES | Middle | Last: MC GREEVY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-34-4207 | 17. INFORMANT Address: HOSP. RECORD - 900 SETON DR. CUMBERLAND, MD. | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Malnutrition | 1 yr |
| Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Dysphagia | 1 yr |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Undiagnosed Neurol. Dis | 10 yr |

2699

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Aspiration Pneumonia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify thot (I) (this hospitol) ottended the deceosed from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceosed olive on _____ 19____, and thot in (my) (aur) opinion deoth occurred on the dote and haur ond from the couses stated abave, (I) (we) (did) (did nat) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: E. Mazzocco M.D. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type): E. MAZZOCCO, M.D. | 22e. ADDRESS: 912 SETON DRIVE, CUMB., MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/25/71 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL HOME | ADDRESS: CUMB., MD. 21502 | 25a. REC'D BY REGISTRAR DATE: JAN 28 1971 | 25b. REGISTRAR'S SIGNATURE: James A. Randall Jr. | |

VR A15 (4) 25m-1/70

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

000645

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Item #6 Film #0432
1/25/71 pcs

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00045 — 00046

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: WALTER | Middle: F. | Last: MC ROBIE | 2a. DATE OF DEATH: JAN Month 8 Day 71 Year | 2b. HOUR: 9:30 A M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 12-17-08 | 6. AGE (In years last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Forman | 12b. KIND OF BUSINESS OR INDUSTRY: Gas Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: GARRETT | 13c. CITY OR TOWN: DEER PARK | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: RT. 3, BOX 140 | |
| 14. FATHER'S NAME First: JOSEPH H. | Middle | Last: MC ROBIE | 15. MOTHER'S MAIDEN NAME First: CLARA N. | Middle | Last: FRELAND |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 577 07 7115 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — |

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. ~~Month Day~~ Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I **certify** that (I) (this hospital) attended the deceased from 12/8/70, 19____, to 1/8/71, 19____, that (I) (~~we~~) last saw the deceased alive on 1/8/71 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature] DOCTOR: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 1/9/71

22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1-10-71 | 23c. NAME OF CEMETERY OR CREMATORY: Garrett Co. Mem. Gardens | 23d. LOCATION (City or Town): Oakland, | (County): Maryland (State) |
| 24. FUNERAL DIRECTOR: Gerald N. Minnich | ADDRESS: Oakland, Maryland | 25a. REC'D BY REGISTRAR DATE: JAN 20 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4)
25m-1/70

1

FOR STATE HEALTH DEPT.

00046

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00047

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farworded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Daniel | Middle: DeSales | Last: Moran | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month: 1 Day: 21 Year: 70 | 2b. HOUR: 4 a M | | | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Feb. 22, 1899 | 6. AGE (In years last birthday): 71 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN.: | 2c. DATE PRONOUNCED DEAD Month: February Day: 3 Year: 1971 | 2d. HOUR: 6 p M |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Westernport | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rural Rt. 1 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Labor | 12b. KIND OF BUSINESS OR INDUSTRY: Textile Fgt. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Westernport | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Route 1 | | | | | |
| 14. FATHER'S NAME First: Daniel | Middle: Moran | Last: | 15. MOTHER'S MAIDEN NAME First: Bridgett | Middle: Gilmore | Last: | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217-14-4640 | 17. INFORMANT ADDRESS: Mary G. Bever-Bloomington, Md. | | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Sclerosis — --
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: February 3, 1971
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 2/5/71 | St. Peters | Westernport, Alle. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. L. Beall | Westernport, Md. | FEB 8 1971 | Thomas R. Randall |

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00047 00048

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JAMES | NMI | MORRIS | 01 13 71 | 10:25A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 05 25 94 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | CUMBERLAND BREWERY | BREWERY |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 850 COLUMBIA AVE. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | | MORRIS | MARTHA | | MORRIS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| YES | 214 05 4826 | PATIENT'S HOSPITAL CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 YEARS

4409

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 12 11 1970, to 1 13, 1971, that (I) (we) last saw the deceased alive on 1 13 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|
| Ralph W. Ballin M.D. | ATTENDING PHYS. [X] | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| RALPH W. BALLIN M.D. J.P. HALLINAN, M.D. | 140 BEDFORD ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/16/71 | St. Patricks Cem. | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| STEIN'S FUNERAL HOME, 117 FREDERICK ST., CUMB., MD. | JAN 20 1971 | Vernon R. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

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00021

JAMES HMI MORRIS 01 13 71 10:25A

MALE WHITE 05 25 04 75

MARYLAND U.S.A. X ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL CUMBERLAND BREWERY BREWERY

MARYLAND ALLEGANY CUMBERLAND X 850 COLUMBIA AVE.

GEORGE MORRIS MARTHA MORRIS

YES 214 05 4626 PATIENT'S HOSPITAL CHART 900 SETON DRIVE CUMBERLAND, MD.

ARTERIOSCLEROSIS 5 YEARS

X

12 11 70 1 13 71

L 13 7L

RALPH W. BALLIN M.D.
J.P. MALLINAN, M.D. 140 BEDFORD ST., CUMBERLAND, MD. 21502

STEIN'S FUNERAL HOME , 117 FREDERICK ST., CUMB., MD.

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00048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00049

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: SALLY | Middle: M. | Last: NEWMAN | 2a. DATE OF DEATH Month: 01 Day: 07 Year: 71 |
| 2b. HOUR: P 12:55 M | | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 04-13-88 | 6. AGE (In years last birthday): 82 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: HOME |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNSYLVANIA | 13b. COUNTY: SOMERSET | 13c. CITY OR TOWN: SALISBURY | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: UNION ST. | | | |
| 14. FATHER'S NAME First: SILAS | Middle: | Last: MAY | 15. MOTHER'S MAIDEN NAME First: ELIZABETH Middle: | Last: SHERRY |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 187-24-4033 | 17. INFORMANT Address: HOSPITAL RECORD, SACRED HEART HOSPITAL | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b): Aortic Stenosis — 10 yr +

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost. 3959

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Orchidectomy

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] DEGREE | ATTENDING PHYS. ☑ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ |
| 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type): EUGENE MAZZOCCO, M.D. | 22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MARYLAND | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 1/10/1971 | 23c. NAME OF CEMETERY OR CREMATORY: SALISBURY-PA I.O.O.F. | 23d. LOCATION (City or Town) (County) (State): SALISBURY-SOMERSET-C- PA | |
| 24. FUNERAL DIRECTOR: Stanley M Thomas | ADDRESS: STANLEY THOMAS FUNERAL HOME, SALISBURY, PENNA. | 25a. REC'D BY REGISTRAR DATE: JAN 11 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4)
45M - 1/69

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**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

00049

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00050

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Lost | 2o. DATE KNOWN OF DEATH ESTIMATED ☒ | Month | Doy | Yeor | 2b. HOUR | | | |
| | Harvey | Francis | Nixon | ☐ | Jan. | 7, | 71 | 9:22a | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | Month | Doy | Yeor | 2d. HOUR | |
| Male | White | 5/ 6/1892 | 78 YRS. | | | | | | January | 7, | 1971 | 9:22a | M |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U S A | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Retired Farmer | |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Oldtown | YES ☐ NO ☒ | Route 1 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Christopher | C. | Nixon | Eliza | E. | Leasure |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 214-07-4996 | Mrs. Anna E. Nixon | Route 1, Oldtown, Md |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCV Disease — --

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: January 7, 1971

ADDRESS (Street, city, town, or county) Cumberland, Maryland

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 1/10/1971 | Davis Memorial Park | Nr. Cumberland | Alleg | Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles E. Hafer — Hafer Funeral Service, 230 Balto Ave. Cumberland Md | JAN 11 1971 | Vernon R. Randall |

VR A15ME (5)
10M REV. 1/68

Item #7b Film #G433
2/2/71 pcs

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00050 00052

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JOHN | NMI | PATITUCCI | 01 18 71 | 1:40PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 09-15-~~84~~ | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| ITALY | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED Grocery Store | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 1001 PIEDMONT AVE. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| LORENZO | | PATITUCCI | CATHERINE | | MOLINERO |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | HOSP.REC.,900 SETON DR.,CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolism. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Thrombophlebitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Emphysema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While [ ] at work Not while [ ] at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan.15, 1971, to Jan.18, 1971, that (I) (we) last saw the deceased alive an Jan.18 1971, and that in (my) (aur) apinian death accurred an the dote and haur and from the causes stated abave, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Clarence V. Vincent M.D. | M.D. | [X] | [ ] | [ ] | Jan.18,1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| CLARENCE VINCENT, M.D. | 924 SETON DR., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan.21,1971 | St. Patrick's Cemetery | Cumberland, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME | JAN 22 1971 | Vernon O. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00051 00053

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| FRANCIS | J. | PATRONE | JAN 13 71 | 7:18 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 2-5-11 | 59 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Paper Maker | Paper Mill |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | MINERAL | PIEDMONT | YES [X] NO [ ] | 15 DUNDEE ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOSEPH | | PATRONE | ROSE | | Gardina |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | W.W. II | 217 50 7264 | MEMORIAL HOSPITAL, | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ca of Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospitol) attended the deceased from 1/7/71, 19__, to 1/13/71, 19__, that (I) (we) last saw the deceased alive on 1/12/71 19__, and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| | MD | [X] | [ ] | [ ] | 1/15/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R. J. WILLIAMS | 122 S. CENTRE ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/16/71 | St. Peters | Westernport-Allegany-Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| BOAL FUNERAL HOME, WESTERNPORT, MD. | JAN 21 1971 | Warren R. Randall |

E. P. Boal

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4) 25m-1/70

1 | 00052

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00054

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| PIETRO | NMI | PRATO | 01 08 71 | 4:40 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 05-21-85 | 85 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| ITALY | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [ ] NO [X] | RT 2, BOX 26 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| THOMAS | | PRATO | MARIE | | BAFERO |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|
| NO | 213-09-8092 | SACRED HEART HOSP. | HOSPITAL CHART, 900 SETON DR., CUMBERLAND, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4220

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ] | HOUR A.M. P.M. Month Day Year 19 | |

| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| While at work [ ] Not while at work [ ] | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 12-1, 1970, to 1-8, 1970, that (I) (we) last saw the deceased alive on 1-8 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W.E. Spiegle | MD | [ ] | [ ] | [ ] | 1-7-70 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ~~V.E. MAZZOCCO, M.D.~~ W.E. SPIEGLE | 912 SETON DR. CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 1/11/71 | ST. MICHAEL'S CEMETERY | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DURST FUNERAL HOME, 57 FROST AVE. FROSTBURG, MD. | JAN 13 1971 | Vernon B. Randall |

VR A15 (4) 25m-1/70

000038

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00053

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00055

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1. DECEASED-NAME (Type or print): First: Grace; Middle: L.; Last: Price

2a. DATE OF DEATH: Month 1 Day 4 Year 71

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: September 4, 1886

6. AGE (In years last birthday): 84 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN

7a. BIRTHPLACE (State or foreign country): Md

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Lonaconing

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 84 Jackson St

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Allegany

13c. CITY OR TOWN: Lonaconing

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 84 Jackson Street

14. FATHER'S NAME: First Russell; Middle; Last Stewart

15. MOTHER'S MAIDEN NAME: First Mary; Middle; Last Barnard

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Velma Broadwater "Daughter" Address: Lonaconing, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: immediate

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Insufficiency — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 56, to 1-4, 19 71, that (I) (we) last saw the deceased alive on 12-23 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: L. R. Miles MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 1-5-71

22d. PHYSICIAN'S NAME (Type): L. R. MILES JR

22e. ADDRESS: LONACONING MD 21539

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1/7/71

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

23d. LOCATION (City or Town) (County) (State): Moscow A. Md

24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: JAN 7 1971

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

1

00054

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00056

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First / Middle / Last | Frank Allen Priddy | 2a. DATE OF DEATH Month / Day / Year | January 3 1971 |
| 2b. HOUR | 4:50PM | | |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH | 11-10-05 | 6. AGE (In years last birthday) | 65 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Tenn. | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | | 9. COUNTY OF DEATH | Allegany Md. |
| 10. CITY OR TOWN OF DEATH | Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Memorial Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Machinist Helper | 12b. KIND OF BUSINESS OR INDUSTRY | Railroad |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | Md. | 13b. COUNTY | Allegany |
| 13c. CITY OR TOWN | Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | |
| 13e. STREET AND NUMBER | 302 Arch Street | | |
| 14. FATHER'S NAME First / Middle / Last | Frank Priddy | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Launa Guthridge |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | 705-09-9469 |
| 17. INFORMANT Address | Memorial Hospital Cumberland, Md. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General Debility + Malnutrition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2699

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Pulmonary Disease - Healed Tuberculosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 12, 1971, to 13, 1971, thot (I) (we) last saw the deceased olive on Jan 3 1971, and that in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Thomas Lusby — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 1/4/71

22d. PHYSICIAN'S NAME (Type) Dr. Thomas Lusby — 22e. ADDRESS 932 National Hgwy., La Vale, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Jan. 6, 1971 | Hillcrest Burial Park | Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS | Scarpelli Funeral Home, Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE | JAN 7 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00055 — 00057

1. DECEASED-NAME (Type or print): First WILLIAM; Middle C.; Last REITMEIER
2a. DATE OF DEATH: 01 Month 25 Day 71 Year
2b. HOUR: M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 03-06-14
6. AGE (In years last birthday): 56 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY, Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Brewery
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 529 COLUMBIA AVE.
14. FATHER'S NAME First JOHN; Middle W.; Last REITMEIER
15. MOTHER'S MAIDEN NAME First MAE; Middle; Last SLOAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wor or dates of service)
16b. SOCIAL SECURITY NO.: 214-05-4802
17. INFORMANT (Address): HOSPITAL RECORD, 900 SETON DRIVE CUMBERLAND, MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
492X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): COR PULMONALE — 2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c): EMPHYSEMA — 6 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify thot (I) (this hospital) ottended the deceased from 12 - 6, 19 69, to 1 - 25, 19 71, that (I) (we) last saw the deceased alive on 1 - 25 1971, and that in (my) (our) opinion death occurred on the dote and hour ond from the causes stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE: R W Ballin M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: Q 1-25-71
22d. PHYSICIAN'S NAME (Type): R.W. BALLIN, M.D.
22e. ADDRESS: 51 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Jan.28,1971
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md.
24. FUNERAL DIRECTOR: KIGHT FUNERAL HOME, 309 DECATUR ST. CUMBERLAND, MD.
25a. RECD BY REGISTRAR DATE: JAN 28 1971
25b. REGISTRAR'S SIGNATURE: Vernon O. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

00052

CERTIFICATE OF DEATH

WILLIAM C. REITMEIER 01 25 71

MALE WHITE 03-06-14 56

X

MARYLAND UNITED STATES ALLEGANY,

CUMBERLAND SACRED HEART HOSPITAL

MARYLAND ALLEGANY CUMBERLAND X 525 COLUMBIA AVE.

JOHN W. REITMEIER MAE SLOAN

NO 214-05-4802 HOSPITAL RECORD, 900 SETON DRIVE CUMBERLAND, MD.

CEREBRO-VASCULAR ACCIDENT 3 DAYS

COR PULMONALE 2 YEARS

EMPHYSEMA 6 YEARS

X

12 - 6 69 1 - 25 71

1 - 25 71

X Q 1-25-71

R.W. BALLIN, M.D. 51 GREENE ST., CUMBERLAND, MD.

KIGHT FUNERAL HOME, 309 DECATUR ST.
CUMBERLAND, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00056

00058

1 FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DH-893. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Carl | Middle: Joseph | Last: Shrake | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Doy Yeor: Jan. 6, '71 | 2b. HOUR: 4 PM | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: June 16, 1915 | 6. AGE (In years last birthday): 55 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year: January 6, 1971 | 2d. HOUR: 4 PM |
| 7a. BIRTHPLACE (State or foreign country): Ohio | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Memorial Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Signalman | 12b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland, | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 808 Piedmont Ave. | |
| 14. FATHER'S NAME First: George | Middle: P. | Last: Shrake | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: -- | Last: Bryant |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes, | (If yes give war or dates of service): W. W. # 2 | 16b. SOCIAL SECURITY NO.: 279-03-7013 | 17. INFORMANT: Mrs. Magdaline Shrake | ADDRESS: 808 Piedmont Ave. Cumb. Md. 21502 | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Thrombosis, left | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 6, 1971

ADDRESS(Street, city, town, or co): Cumberland, Marylan

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/11/71 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem. | 23d. LOCATION (City or Town) (County) (State): Zanesville, Muskingum Ohio | |
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: 202 Greene St. Cumberland, Md. 21502 | 25a. REC'D BY REGISTRAR DATE: JAN 11 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon D. Randall | |

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00057 00059

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Earl | L. | Sills | Jan. 8 1971 | 4:38 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| male | white | 4-6-1896 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Cumberland Md. | U.S. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sylvan Retreat | Retired Foreman | Brewery |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 623 Lincoln St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| J. | Walton | Sills | Catherine | | Shaffer |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | WW I | | Records | Sylvan Retreat |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 4100

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac decompensation

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) yrs; (b) days; (c) day

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 6/5, 19 7c, to 1/8, 19 71, that (I) (we) last saw the deceased alive on 1/7 19 71, and that in (my) (aur) opinian death accurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| George M Simons | | ☒ | ☐ | ☐ | 1/9/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| George M. Simons | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/10/71 | Hillcrest Burial Pk | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lewis Stein Inc. | Cumberland Md. | JAN 14 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removol, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00058

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00060

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Elmer | S | Simpson | 1/18/1971 | 5 aM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 19 | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | May 9th. 1901 | 69 YRS. | | | | | 1/18/1971 | 7 aM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Lonaconing | 27 Rockville St. | Retired Carpenter | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | Allegany | Lonaconing | YES ☐ NO ☒ | 27 Rockville St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Donald | | Simpson | Mary | M. | Warnick |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | | Mrs. Mildred Simpson, Lonaconing, MD. (WIFE) |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. / BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 1/18/1971

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/20/1971 | Grantsville Cemetery | Grantsville, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| George Eichhorn Lonaconing, Md. | JAN 22 1971 | Vernon R. Randall |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 93. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

4 1

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00059

## CERTIFICATE OF DEATH

00061

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Sarah | P | Sisler | 1 | 24 | 71 | 10:45 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| F | W | 7-23-95 | 75 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Eglon W. Va. | U.S. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Cumb. Nursing Center | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| West Virginia | Mineral | Wiley Ford | YES ☑ NO ☐ | Box 167 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ~~Henry~~ John | | Snyder | Susan ~~Anna~~ | | Glass |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | 233-46-9929 | Mr. Dan Sisler | 246 Welch Hill Frostburg, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 mos
DUE TO, OR AS A CONSEQUENCE OF
(b) Probably primary in lung — 3 years
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| Nov 70 | Metastatic cancer | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from Sept, 1970, to 27 Jan, 1971, that (I) (we) last saw the deceased alive on 27 Jan 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Jos. W. Militello Jr | M.D. | ☒ | ☐ | ☐ | 26 Jan 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/27/1971 | Davis Memorial Park | Nr. Cumberland Alleg Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hafer Funeral Service | 230 Balto Ave. Cumberland Md | JAN 29 1971 | Vernon R. Randall |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00060 00062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EARL | Middle: | Last: SMITH | 2a. DATE OF DEATH Month: 1 Day: 15 Year: 71 | 2b. HOUR: 1:05 A.M. | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: JULY 4, 1894 | 6. AGE (In years last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY: CLEANERS | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 109 PARK ST. | | |
| 14. FATHER'S NAME First: JOHN | Middle: K | Last: SMITH | 15. MOTHER'S MAIDEN NAME First: NOLIE | Middle: | Last: GLEN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES | (If yes give war or dates of service): WW 1 | 16b. SOCIAL SECURITY NO.: 220-10-7785 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD. | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
481 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Coronary artery disease.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this hospitol) attended the deceased from ____, 19 71, to 1/15, 19 71, that (I) (we) last saw the deceased alive on 1/14, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD — DEGREE — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] — 22c. DATE SIGNED: 1/17/71

22d. PHYSICIAN'S NAME (Type): BRAD MEDICAL GROUP — 22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/18/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town): Nr. Cumberland | (County): Alleg | (State): Md |
| 24. FUNERAL DIRECTOR: HAFER FUNERAL HOME | ADDRESS: CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: JAN 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00061 00063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EARL | Middle: C, | Last: SMITH | 2a. DATE OF DEATH Month: 01 Day: 09 Year: 71 | 2b. HOUR: 11:15 P |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 12-07-11 | 6. AGE (In years last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY COUNTY | | Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): IRON WORKER | 12b. KIND OF BUSINESS OR INDUSTRY: IRON WORKERS | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: WEST VA. | 13b. COUNTY: MINERAL | 13c. CITY OR TOWN: RIDGELEY | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 80 KNOBLEY STREET | |
| 14. FATHER'S NAME First: GEORGE | Middle: | Last: SMITH | 15. MOTHER'S MAIDEN NAME First: SARAH | Middle: | Last: ROTH |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-07-0659 | 17. INFORMANT: HOSPITAL RECORD, SACRED HEART, 900 SETON DRIVE, CUMBERLAND, MD. | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolism

DUE TO, OR AS A CONSEQUENCE OF (b): Intramural Thrombi

DUE TO, OR AS A CONSEQUENCE OF (c): Acute myocardial infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinian death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Clarence J. Vincent M.D. DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type): CLARENCE VINCENT, M.D. | 22e. ADDRESS: 924 SETON DRIVE, CUMBERLAND, MARYLAND | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: JAN. 12, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: REST LAWN MEMORIAL PARK | 23d. LOCATION (City or Town): LAVALE | (County): ALLEGANY (State): MARYLAND |
| 24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL HOME, ADDRESS: 404 DECATUR ST. CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: JAN 14 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | | |

VR A15 (4)
25m-1/70

EARL C. SMITH

MALE WHITE 12-07-11 52

MARYLAND UNITED STATES ALLEGANY COUNTY

CUMBERLAND SACRED HEART IRON WORKER IRON WORKERS

WEST VA. MINERAL RIDGELEY X 20 KNOBLEY STREET

GEORGE SMITH SARAH ROTH

NO 214-07-0152 HOSPITAL RECORD, SACRED HEART, 200 SETON DRIVE, CUMBERLAND, MD.

CLARENCE VINCENT, M.D. 224 SETON DRIVE, CUMBERLAND, MARYLAND

SILCOX-HERRITT FUNERAL HOME, 404 DECATUR ST. CUMBERLAND, MD.

1

00062

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00064

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Ida | Middle: Inez | Last: Smith | 2a. DATE OF DEATH: Month Jan. Day 24 1971 | 2b. HOUR: 4:45 P.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: 10-23-96 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Penna. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Sylvan Retreat | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 183 N. Centre Street | |
| 14. FATHER'S NAME First: Joseph | Middle: A. | Last: Smith | 15. MOTHER'S MAIDEN NAME First: Savannah | Middle: | Last: Robinson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-56-8897T | 17. INFORMANT: Mary Smith | Address: Fostoria, Ohio | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion - acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Chr. A.S.H.D. — many years.

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis — many years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Benign tumor of endometrium '66.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospitol) attended the deceased from April 15 19 68, to Jan. 24, 1971, that (I) (we) last saw the deceased olive on Jan. 25 19 71, and thot in (my) (our) opinion deoth occurred on the date ond haur and from the couses stated above, (I) (we) (did) (did nat) view the bady after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: John A Tepper MD | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☑ | 22c. DATE SIGNED: 1-26-71 |
| 22d. PHYSICIAN'S NAME (Type): John A Tepper MD | | 22e. ADDRESS | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Jan. 27, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery | 23d. LOCATION (City or Town): Artemas | (County): Bedford | (State): Penna. |
| 24. FUNERAL DIRECTOR: Byron Kight | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: JAN 28 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | | |

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M · 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

00063

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00065

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Robert | Middle: M | Last: Smith | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 1-28-71 Day | Year: 1911 | 2b. HOUR: 1:20a M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 27 July 1927 | 6. AGE (In years last birthday): 43 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month: January Day: 28, 1971 Year 19 11 | 2d. HOUR: 1:20a M | | |
| 7a. BIRTHPLACE (State or foreign country): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Operator | 12b. KIND OF BUSINESS OR INDUSTRY: Alleg. Ballistics | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va. | 13b. COUNTY: Mineral | 13c. CITY OR TOWN: Keyser | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 1325 Lynmar Street | | | |
| 14. FATHER'S NAME First: Edward | Middle: M. | Last: Smith | 15. MOTHER'S MAIDEN NAME First: Beulah | Middle: M. | Last: Hull | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 220 26 9560 | 17. INFORMANT: Mary B. Smith | ADDRESS: Keyser, W.Va. | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4109 Myocardial Infarction, Left — Approximate Interval Between Onset and Death: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Thrombosis, left — Approximate Interval Between Onset and Death: "

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis — Approximate Interval Between Onset and Death: ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Also old Myocardial Infarctions, Left

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [XX] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 28, 1971

ADDRESS (Street, city, town, or county)

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 31 Jan 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Queens Point | 23d. LOCATION (City or Town) (County) (State): Keyser, Mineral W.Va. | |
| 24. FUNERAL DIRECTOR: Allen M. Ratcliff | ADDRESS: Keyser, W.Va. | 25a. REC'D BY REGISTRAR DATE: FEB 3 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00064 — 00066

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type ar print) | First: COIT | Middle: M. | Last: SPEICHER | 2a. DATE OF DEATH Month: 01 Day: 17 Year: 71 | | 2b. HOUR: 8 P M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 03-28-04 | 6. AGE (In years last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY, Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind af wark dane during mast of working life, even if retired.): KELLY SPRINGFIELD TIRE CO. | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: 38 ORCHARD STREET, BOWLING GREEN | | |
| 14. FATHER'S NAME First: HENRY | Middle | Last: SPEICHER | 15. MOTHER'S MAIDEN NAME First: SADIE | Middle | Last: GNAGEY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-07-0494 | 17. INFORMANT: HOSPITAL CHART, Address: SACRED HEART HOSPITAL, 900 SETON DR., CUMBERLAND, MD | | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Hepatic Failure | 3 mo |
| DUE TO, OR AS A CONSEQUENCE OF (b) | metastatic Carcinoma | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Carcinoma of Colon | 3 yr |

Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS [ ] UNDERLYING OR [ ] CONTRIBUTING CAUSE OF DEATH (If either, natify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature af injury in Part I ar Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at wark [ ] Nat while at wark [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street ar R.F.D. Na. / City ar Town / Caunty / State |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: V.E. Mazzocco DEGREE | ATTENDING PHYS. [X] | MED DIRECTOR [ ] | STAFF PHYS. [ ] |
| 22c. DATE SIGNED: 1-18-71 | | | |
| 22d. PHYSICIAN'S NAME (Type): V.E. MAZZOCCO, M.D. | 22e. ADDRESS: 912 SETON DR., CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: JAN 20, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: ST PAUL'S CEMETERY | 23d. LOCATION (City ar Tawn): ACCIDENT | (Caunty): GARRETT | (State): MARYLAND |
| 24. FUNERAL DIRECTOR: SILCOX, MERRITT FUNERAL HOME | ADDRESS: 404 DECATUR ST. CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: JAN 20 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | | |

VR A15 (4) 25m-1/70

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

00065 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00067

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Edward | Middle: Arthur | Last: Taschenberger | 2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Doy Year: Jan. 6, 1971 | | 2b. HOUR: 8a M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 5/18/1906 | 6. AGE (In years last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year: Jan. 6, 1971 | 2d. HOUR: 9a M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany | | Md. |
| 10. CITY OR TOWN OF DEATH: Route 4, Cumberland Md | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): At Home Route4 Cumberland, Md | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Auto Parts | 12b. KIND OF BUSINESS OR INDUSTRY: Self | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: ~~Route 4~~ Cumberland | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: Route 4, Box 279 | |
| 14. FATHER'S NAME First: William | Middle: O. | Last: Taschenberger | 15. MOTHER'S MAIDEN NAME First: Frances | Middle: A. | Last: Little |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Stella Taschenberger | ADDRESS: Cumberland, Md. Route 4, Box 279 | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): (Self-Inflicted)
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955x

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I taak charge af the remains described abave, held an Autopsy [X], Inspectian [X], Inquiry [X] and in my apinian death resulted fram: Natural causes [ ], Accident [ ], Suicide [X], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: Jan. 6, 1971
ADDRESS(Street, city, town or county): Cumberland, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 1/ 9/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park | 23d. LOCATION (City or Town) (County) (State): Near Cumberland Alleg Md | |
| 24. FUNERAL DIRECTOR: Charles E. Hafer | ADDRESS: Hafer Funeral Service, 230 Balto Ave. Cumberland Md | 25a. REC'D BY REGISTRAR: JAN 8 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15ME (5)
10M REV. 1/68

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

00066

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00068

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| SHANE | N | TAYLOR | ☒ / ☐ | 1- | 31- | 71 | 10:45a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | Jan. 4, 1971 | YRS. | | 27 | | | JANUARY 31, 1971 | 10L45 M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | NEVER MARRIED ☒ | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL--DOA | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | ~~XXXXXXXXX~~ Frostburg | YES ☐ NO ☒ | R.R. #1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Gregory | | Taylor | ANDREA | | NEILSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | NONE | GREGORY TAYLOR, RT. 1, FROSTBURG, MD. 21532 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Anoxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

7469

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Congenital Heart Disease — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED: January 31, 1971

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR ~~CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 2-1-1971 | FROSTBURG MEMORIAL PARK | FROSTBURG ALLEG. MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Durst Funeral Home | FROSTBURG, MD. | FEB 3 1971 | Vernon G. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M · 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00067

# CERTIFICATE OF DEATH

00069

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIOLA | ZOE | TRULY | JANUARY 23, 1971 | 10:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | OCTOBER 20, 1887 | 83 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | 84 HILL STREET | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | X | 84 HILL STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PETER | | WHETSTONE | RACHEL | | MILLER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | N.A. | NONE | MRS. EMMETT CALLIN | 176 ORMOND ST., FROSTBURG, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) q-S-C-V-D.
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) C-V-A

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) — (c) 3470.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Senility

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 4-2, 19 70, to 1-23, 19 71, that (I) ~~(we)~~ last saw the deceased alive on 1-22 19 71, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| H.C. Diehl, M.D. | | ☒ | ☐ | ☐ | 1/25/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| H.C. DIEHL, M.D. | 39 W. MAIN ST., FROSTBURG, MD. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 1/26/71 | FROSTBURG MEM. PARK | FROSTBURG, ALLEGANY MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARILOU M. SOWERS, Marilou M. Sowers | HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG | FEB 1 1971 | Vernon G. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

00068

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00070

1 FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. BMS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M I

1. DECEASED-NAME (Type or Print): First GILBERT Middle L. Last TWIGG

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year 1-23-71 19 11

2b. HOUR: 11:30 a M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Nov. 18,1917

6. AGE (In years last birthday): ~~53~~ 53 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month Day Year January 23-1971 19 11

2d. HOUR: 11:30 a M

7a. BIRTHPLACE (State or foreign country): W. Va.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL--DOA

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): SHIPYARD

12b. KIND OF BUSINESS OR INDUSTRY: SHIPYARD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: RURAL ROUTE

14. FATHER'S NAME: First Middle Last George H. Twigg

15. MOTHER'S MAIDEN NAME: First Middle Last Mary J. Betts

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW2

16b. SOCIAL SECURITY NO.: 220-10-9199

17. INFORMANT: Mrs. Martha Twigg, Bedford Rd. Cumberland, Md. ADDRESS RD#3 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

481X

IMMEDIATE CAUSE (a): LOBAR PNEUMONIA, LEFT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 Days

DUE TO, OR AS A CONSEQUENCE OF (b): (PNEUMOCOCCUS)

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: JANUARY 23, 1971

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Jan. 26,1971

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (State): Cumberland, Md. RD3 Allegany

24. FUNERAL DIRECTOR: ZIEGLER FUNERAL HOME ADDRESS: Hyndman, Pa. 15545

25a. REC'D BY REGISTRAR DATE: JAN 27 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

VR A15ME (5) 10M - 1/69

4 1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00069 00071

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| ELMER | ELWOOD | TYSINGER | 1 | 4 | 71 | 7:50A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 8-1-96 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| VIRGINIA | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Ret. Carman | B. & O. Rwy |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | Mineral | WILEY FORD | YES [ ] NO [X] | Swan Pond Road |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Charles | I. | TYSINGER | SARAH | | IRT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No, | 705-09-9664 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pneumonia | months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Cerebral arteriosclerosis | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Prostate Malignancy | months |

4/23

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from January 1, 1971, to January 4, 1971, that (I) (we) last saw the deceased alive on January 4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 1/4/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. B. SCHINDLER-PA | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 1/7/71 | Zion Memorial Park | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | JAN 11 1971 | Vernon O. Randall |

VR A15 (4)
25m-1/70

Item #6 Film #GL32
1/18/71 pcs

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00070

00072

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| AGNES | J. | VALENTINE | 1 2 1971 | 1:20 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 11/13/93 | 77 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| BAXTER, W. VA | UNITED STATES | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD | CUMBERLAND NURSING CENTER | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. Va. | | New Creek | | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Riley | | Davis | Laura | | Hess |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 215-20-9812 | Ernest Valentine | New Creek, W. Va. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

1519
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Old age.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5/30, 1970, to 1/2, 1971, that (I) (we) last saw the deceased alive on 12/30 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| P B Halmos MD | MD | ☑ | ☐ | ☐ | 1/2/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| P. B. HALMOS | 302 Sublett St. Cumberland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5 Jan 71 | Queens Point | Keyser Mineral W. Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Allen M. Patrick | Keyser, W. Va. | JAN 11 1971 | Vernon R. Randall |

VR A15 (4)
45M - 1/69

1
FOR STATE HEALTH DEPT.

00071

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00073

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: LLOYD | Middle: HERSEY | Last: WADE | 2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month: 1-24-71 Day | Year: 19 | 2b. HOUR: 4:20p M | |
| 3. SEX: Male | 4. RACE: white | 5. DATE OF BIRTH: MARCH 3, 1895 | 6. AGE (In years last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month: January Day: 24. Year: 19 71 | 2d. HOUR: 4:20p M | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND FROSTBURG, | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER | 12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: MT. SAVAGE | 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] | 13e. STREET AND NUMBER: CHURCH HILL | | |
| 14. FATHER'S NAME First: WILBER | Middle: | Last: WADE | 15. MOTHER'S MAIDEN NAME First: EMMA | Middle: | Last: CESSNA | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If yes give war or dates of service): N.A. | 16b. SOCIAL SECURITY NO.: 212-14-1623 | 17. INFORMANT: MRS. LLOYD H. WADE, NEW ROW, MT. | ADDRESS: SAVAGE, MD. 21545 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY THROMBOSIS | " |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CORONARY SCLEROSIS | --- |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [XX] Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: January 24, 1971

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 1/27/71 | 23c. NAME OF CEMETERY OR CREMATORY: ST. GEORGE'S EPIS. CEM. | 23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, ALLEGANY, MD. | |
| 24. FUNERAL DIRECTOR: Hafer-Sowers | ADDRESS: 60 W. MAIN, FROSTBURG FUNERAL HOME | 25a. REC'D BY REGISTRAR DATE: FEB 1 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon A. Randall | |

VR A15ME (5)
10M - IV 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00072

# CERTIFICATE OF DEATH

00074

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| MARY | J | WATKINS | JAN | 18 | 71 | 10:20 |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | 2-10-91 | 79 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | ECKHART | YES ☐ NO ☐ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | LEE | | JEAN | | WILLISON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 213-09-6594-A | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4409
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1/15, 1971, to 1/18, 1971, that (I) (we) last saw the deceased alive on 1/13 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William R Jeeves MD | | ☒ | ☐ | ☐ | 1/20/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W.P. JAMES | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | JAN. 21, 1971 | ECKHART CEMETERY | ECKHART, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | JAN 25 1971 | Vernon R Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00073 00075

1. DECEASED-NAME (Type or print): First CLARA; Middle E; Last WEAVER

2o. DATE OF DEATH: Month 1 Doy 14 Yeor 71

2b. HOUR: 3:55 PM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: 9-29-91

6. AGE (In yeors lost birthday): 79 YRS.

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

7o. BIRTHPLACE (Stote or foreign country): W.VA.

7b. CITIZEN OF WHAT COUNTRY? UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL HOSPITAL

12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY

13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 536 EASTERN AVE.

14. FATHER'S NAME: First ALBERT; Middle A.; Last DAWSON

15. MOTHER'S MAIDEN NAME: First MARY; Middle; Last SWARTZ

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 217-10-6236B

17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o): uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b): Congestive Heart Failure & CVA — 2 months

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized arteriosclerosis — years

4369 Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20o. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical exominer)

21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work [ ] Not while ot work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1970, to Jan 14, 1971, that (I) (we) last saw the deceased alive on Jan 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B M Schindler M.D. DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 1/14/71

22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER, PA

22e. ADDRESS: CUMBERLAND, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 1/16/71

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d. LOCATION (City or Town) (County) (Stote): Cumberland Allegany Md.

24. FUNERAL DIRECTOR: Silcox-Merritt Fun. Ser.

ADDRESS: 404 Decatur St. Cumberland, Md.

25o. REC'D BY REGISTRAR DATE: JAN 18 1971

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

00074 00076

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| IRVIN | M. | WEIMER | 01 19 71 | 12:30P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 03-19-98 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED | Mining |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| ~~PENNSYLVANIA~~ Maryland | ~~XXXXXXXXX~~ Allegany | HYNDMAN | YES [ ] NO [X] | ROUTE 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| THEODORE | | WEIMER | ALPHARETTA | | BITTNER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 705-12-5539 | HOSP.,REC.,900 SETON DR.,CUMB.,MD.21502 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PNEUMOTHORAX (R) LUNG — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) C.O.P.D. & BLEB FORMATION A.

DUE TO, OR AS A CONSEQUENCE OF (c) POST LOBECTOMY FOR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CARCINOMA LEFT LUNG

| 19a. DATE OF OPERATION | 19b. CONDITIONS FOR WHICH OPERATIONS PERFORMED | 20a. AUTOPSY? | 20b. AUTOPSY FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 1-12-71 | CA OF LEFT LUNG PNEUMOTHORAX BILATERAL | YES [X] NO [ ] | YES |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / CONTRIBUTING | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 1-3, 19 71, to 1-19, 19 71, that (I) (we) last saw the deceased alive on 1-19 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHY. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|
| Matthew L Kaufman MD | X | | | 1-19-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| MATTHEW KAUFMAN, M.D. | 924 SETON DR., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | JAnuary 23,1971 | Comps Cemetery | Hyndman, Pa. RD#1 Somerset Co. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| ZIEGLER FUNERAL HOME.,HYNDMAN, PA. 15545 | JAN 27 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1

00075

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00077

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Albert | Cheston | White | 1 | 7 | 71 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | June 1, 1896 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg | Miners Hospital | Retired Glass Worker | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Allegany | Lonaconing | YES [ ] NO [X] | Charlestown St |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Walter | | White | Elizabeth | | McLaughlin |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | Mrs. Mary White "Wife" | Lonaconing, Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial Ischemia | days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerosis | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Blood loss anemia Chronic Gastritis - Pulmonary fibrosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1-6, 19 71, to 1-7, 19 71, that (I) (we) last saw the deceased alive on 1-7-71 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L. R. Miles MD | MD | [X] | [ ] | [ ] | 1-8-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. R. MILES JR. | LONACONING, MD. 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 1/10/71 | Oak Hill Cemetery | Lonaconing | A. | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George Eichhorn | Lonaconing, Maryland. | JAN 11 1971 | Vernon R. Randall |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00076 00078

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | FANNIE | Middle | B. | Last | WHITE |
| 2a. DATE OF DEATH Month | 01 | Doy | 23 | Year | 71 |
| 2b. HOUR | 5:15 M | | | | |
| 3. SEX | FEMALE | | | | |
| 4. RACE | WHITE | | | | |
| 5. DATE OF BIRTH | March 5, 1887 | | | | |
| 6. AGE (In years last birthday) | 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | PENNA | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | | |
| 9. COUNTY OF DEATH | ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | MEMORIAL HOSPITAL | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Retired | | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Beautician | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | MARYLAND | 13b. COUNTY | ALLEGANY | 13c. CITY OR TOWN | CUMBERLAND |
| 13d. INSIDE CITY LIMITS? | YES ☒ NO ☐ | 13e. STREET AND NUMBER | 26 GREENE STREET | | |
| 14. FATHER'S NAME First | ALFRED | Middle | BRYAN | Last | |
| 15. MOTHER'S MAIDEN NAME First | EMMA | Middle | | Last | Unknown |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | No | (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | 214-05-9027 | | | | |
| 17. INFORMANT Address | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 days / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 13 19 71, to Jan 23 19 71, that (I) (we) last saw the deceased alive on Jan 23 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | B. M. Schindler MD | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ |
| 22c. DATE SIGNED | 1/25/71 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | DR. B. SCHINDLER, PA | 22e. ADDRESS | CUMBERLAND, MD. | | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | 1/25/71 | 23c. NAME OF CEMETERY OR CREMATORY | Sunset Memorial Park |
| 23d. LOCATION (City or Town) (County) (State) | Cumberland Allegany Md. | | | | |
| 24. FUNERAL DIRECTOR | Silcox-Merritt Fun. Ser. | ADDRESS | 404 Decatur St. Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE | JAN 28 1971 |
| 25b. REGISTRAR'S SIGNATURE | Vernon R. Randall | | | | |

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

00077 00079

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| SYLVESTER | W. | WICKARD | JANUARY 2, 1971 | 12:40 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 05-06-02 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | BOTTLING DEPT? | BREWERY |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 700 LAFAYETTE AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | R. | WICKARD | (MC KENZIE) ANNA | | WICKARD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214-05-4998 | HOSP. RECORD-900 SETON DRIVE, CUMB., MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| Sept 70 | Same | YES NO X | |

| 21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING ☐ | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from July, 19 70, to 2 Jan, 19 90, that (I) (we) last saw the deceased alive on 1 Jan 19 71 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| F.W. Miltenberger M.D. | M.D. | X | ☐ | ☐ | 4 Jan 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| F.W. MILTENBERGER, M.D. | 122 S. CENTRE ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan. 4, 1971 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME, 108 VIRGINIA AVE., CUMB., MD. 21502 | JAN 7 1971 | Vernon A. Rudd Jr |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00078

# CERTIFICATE OF DEATH

00080

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| GEORGE | E. | WILLIAMS | 01 | 24 | 71 | 11:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | 09-26-07 | 63 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | ENGINEER | TELEPHONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 317 CAROLINE STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GROVER | C. | WILLIAMS | (GRUBER) MARY | K. | WILLIAMS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| NO | | 212-05-0805 | SACRED HEART HOSP., 900 SETON DR., CUMBERLAND MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) A.S.C.V.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

+109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute cholecystitis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify thot (I) (this hospitol) ottended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Clarence J. Vincent M.D. | | ☒ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| CLARENCE VINCENT, M.D. | 914 SETON DR., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Jan.28,1971 | Rest Haven Cemetery MD. 21502 | Hagerstown, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB., | JAN 28 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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